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ABSTRACT

This document contains seven papers from the ninth World Conference of Therapeutic Communities (TCs) that deal with adolescent clients and TCs. Papers include: (1) Preliminary Consideration on "Adolescence and the TC" (David Deitch); (2) "Daytop's Full Service Adolescent Treatment Program" (Charles Devlin and Lois Morris); (3) "Adolescent Substance Abusers in the TC: Treatment Outcomes" (George De Leon); (4) "The Child Abuse-Delinquency Connection: Implications for Judicial and Treatment Personnel" (David Sandberg); (5) "The TC as a Model for Effective Adolescent Learning" (Becky Bailey-Findley); (6) "New Morning for Colombian Youth" (Josefina Gallardo de Parejo); and (7) "Sports, Drug Abuse and Teenagers" (Delvin Williams). (NB)

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CHAPTER 6

ADOLESCENT SERVICES & THE TC

PRELIMINARY CONSIDERATION ON ADOLESCENCE AND THE TC

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Adolescence and its attendant difficulties is one subject we can discuss at this international meeting with clear commonality. What is treatment, and more importantly, what is (or should be) adolescent therapeutic community treatment, may be subjects of less commonality and, as we shall see, maybe even serious debate. There are currently only two published chapters on therapeutic community treatment of the adolescent, in 1976 by Deitch & Zweben, and a N.I.D.A. monograph in 1985 by DeLeon & Deitch. Both should be read. Both show a shift and a growing appreciation of the complications with this population, and both describe psychological, psychodynamic and developmental issues.

Most of what adolescents experience, feel and must gain maturity over is common to all cultures -- American, European, Asian, Indian, African, etc. Yes, it is true that in one culture there may be greater latitude regarding, let's say, sex, than in another. Or some culture may have greater restriction than another regarding work, etc. But in all, adolescence is a time of testing limits and personal turbulence and is stressful for all -- the adolescent, the parents, and the culture.

Overall, the task of adolescence is to gain maturity, to take on a new adult (albeit young) role. What one faces in adolescence is complex; the task is immense. Let us look at a little of it. During this period the kid plunges through unprecedented change after change: hormones, weight, emotions, relationships, thinking, ideology and on and on. The relative stability of the preceding years is gone; coping skills are seriously challenged. Social aspirations and demands change almost daily. Decisions of seemingly major proportions must be made, invariably without enough experience or data. This new process involves forging not only a new sense of identity but, in fact, an altered identity. This new process of forging a new sense of identity is often done at least partly by rejecting values and identity given him and shared by the parents and, of course, by synthesizing the outcome of his/her identification with peers and other adults. Characterizations which were once accepted at face value during adolescence (such as the good child, serious, or frivolous) were for the most part expressed by parents, family and teachers identified with family. As peers become important, what may have been viewed as undesirable by parents can be found as interesting or desirable to peers. The serious student may be ostracized, and so forth. These feedback mechanisms and the need for separation from the "sticky" parental relationship may result in the following:

1) a crisis in the adolescent;

2) a profound sense of disappointment and devaluing;

3) lots of self-perceived inadequacies;

4) a profound sense of poor preparation by parents for the stress peers.

This may lead to further devaluing of ideas, values and behaviors which once resulted in positive behavior from parents. Suddenly overwhelming despair occurs. Adolescents want what they see themselves as not already being, overvaluing that which they are not and undervaluing that which they are. For a variety of reasons, there is immense denial of the process or many of the feelings. Usually the stress precipitates strong feelings which can't have clear focus. These un-understandable feelings cause even further stress, so things have to be done with urgency -- fast. An attempt to compensate and to be competent in a hurry often means taking actions which are inappropriate to meeting needs: sex instead of closeness, competition instead of mastery, and over-involvement in a limited role which gets recognition by peers, dopers, jocks, nerds, etc. Further, the adolescent within this naturally occurring time of crisis may not feel free to discuss or explore the nature of his/her experiences. The possible reasons for this are many. Let me just list some:

1) Role modeling by significant adults and the culture suggests no need for discomfort;

2) Lack of experience regarding talking about oneself;

3) Shame at disclosure;

4) Lack of self esteem;

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5) Guilt concerning feelings and desires;

6) Perceptions that peers don't have the same problems; and finally,

7) conflicts with parents.

Without the ability to communicate, without relief of feelings, without relief of stress, the vulnerability is to shift toward inappropriate means. And in the culture there are drugs -- everywhere. So treating adolescents is becoming more popular, more sought after. Why?

1) Certainly our children are closer to us in adolescence, while still living with us. Clearly the culture shares this view, this memory.

2) The adult drug dependent addict/abuser is less sympathetic an image. It's a choice they made and considering the crime associated with drug addiction, the adult addict is often thought of as a thug, an enemy, or needing harsher consequences -- not treatment. But the kid, whose fault it that? And indeed, the question of fault, guilt, creates problems for the treaters.

3) Prevention efforts aimed at youth are under way.

4) Finally, adolescent treatment is now, in terms of ugly statistics, clearly necessary and clearly mandated.

Fact: 21 to 25 year olds and older report, on the average, drug use starting at age 17. In just five years that average has dropped so that our adolescent clients show, on the average, beginning drug use at age 11 to 13.

Fact: While marijuana use has finally reached a plateau (for now) at 40% of the U.S. population, it is the greatest of any industrialized nation on earth.

Fact: Cocaine use among youth has increased in the northeast, and by latest trends, in the west (California).

So, indeed, there are compelling reasons for both the need for and the popularity of adolescent treatment. But now let us pause for a moment. Let me remind you that just as what adolescents experience and how they behave is universal, there is also the fact that since time immemorial they have misbehaved, acted out, and throughout history often acted out with intoxicants. Junenal, in his third satire on the city of Rome, moans about the young hoodlums all steamed up on wine who started street fights for no reasons at all. St. Augustine, speaks of his own teen years, drinking and theft urged on not by poverty, but from a certain distaste for well-being. Wagner, the composer, talks of his adolescent involvement with violence, acting out rage in the surge of intoxification. Max Gorky talks of his own crime and thievery being condoned by elders whose own poverty viewed this as a way of keeping body and soul together.

Certainly the need to defy, to test limits, to push, to challenge is universal and consistent throughout the history of our species. As Religio Medici said, "Every man is not only himself, men are lived over again. The world is now as it was in ages past." Yet there are now real differences. For example, since time immemorial cultures have taken steps to curtail, to correct misbehavior. In adolescence these steps, until the last 50 years, would be perceived as highly punitive and horribly excessive -- ranging from imprisonment to being whipped, to solitary confinement, and, in some instances in every culture, death, albeit for different reasons ranging from theft to more serious crimes. The point is that for centuries all cultures have perceived the need to curtail, channel, direct and shape adolescents so that they can play roles perceived by the adults to be meaningful or at least not destructive. This is, of course, not easy in a rapidly changing world whose values and roles are at best currently confusing. To paraphrase Erickson, "When everything is expanding, it's hard to be integrating."

We in the therapeutic community represent a point of view, a position on values, on behavior, on the way one approaches life. That is, in order to unlearn bad, one must both learn good and do good. We, just be reviewing history, know the value of structured experiences for youth under the leadership of elders and teachers where discipline and challenge permit the productive channeling of young energy into productive and valued social roles. This was not considered treatment, it was considered preparation for life. Today I am at a preliminary point, a place where I need dialogue, feedback, discussion.

Fact: Data tells us it takes twice as long with adolescents to achieve improvement as it does with adults; twice as long for improvement. What the data does not tell us is, depending on what age, for how long subsequent to discharge?

Further, I ask you, what is treatment? Is it to achieve the cessation of the negative behavior? Or is it the cessation of negative behavior and the development of new, positive, socially valued and personally rewarding behavior? We all know the incorporation of a new real identity takes time. If we were in a different setting, no parent, no buyer would be startled if we told them, "To become a good skier, tennis player, musician, it's going to take 18 months to 2 years, or maybe longer, depending on native skills."

We certainly know that adolescents are moved at this age by the peer culture. We certainly know how pervasive drug use is in the adolescent peer culture. We certainly know that this period is loaded, as described, with stresses. And, finally, we know how easy it is to trigger behavior patterns biochemically with just one reintroduction of a drug! We know this. We further know that the TC can achieve more challenging demand and task performance than any dyadic or single parent structure. Just ask them. They say, "How did you get my kid to do that? He never would at home."

We certainly know that TC's can achieve more classroom participation and homework activity than any regular school. We certainly know that our task is cognitive growth, social skill growth, emotional growth and value growth. And that, in fact, if we are to achieve ending self destructive drug abuse, that is what is needed.

Now the problem is that everybody wants the adolescent drug use problem fixed fast and cheaply -- the magic bullet -- the very same type that was used on the mental health system. Just treat crises and do the rest in the streets. I remind you that's what made the nightmare that we live with today with the walking dead, freezing and slowly, brutally ending their days in every city in growing numbers across the country. What made the nightmare possible were practitioners and administrators, not just funders, who said they could do it and should do it.

Yes, parents want their children back quickly. The want the wound, the pain that must occur in treatment, to end and frequently end it prematurely. And, yes, parents want their kids' intoxicant use changed, but not their own. And how long does it take to armor a kid against that? And, yes, many family therapists view all adolescent drug use as a sign of family pathology, nothing more or less, and feel after short-term inpatient they can do the rest. And, yes, of course, the social service agencies desire that it be done less expensively, or more quickly. Funders say, "What about recovery houses?" and "Look at those short term hospital units" without examining the overall costs (social and others) of repeated, serial readmissions until the total exhaustion of insurance and personal finance resources.

But right now the data doesn't look like it can be done right in less that 18 months to perhaps three years. I need your thinking, considering what is occurring in the culture, to give these kids a chance, these kids whose level of personal, familial, school and social dysfunction requires a residential therapeutic community.

DAYTOP'S FULL SERVICE ADOLESCENT TREATMENT PROGRAM

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Recent developments within the drug abuse field, including the holding of a First Conference on Adolescent Treatment this year, and the revealing 1985 survey data from the New York Division of Substance Abuse Services, have highlighted the importance of adolescent treatment within the TC. This paper describes Daytop's comprehensive approach to adolescent treatment -- a full service adolescent treatment program which includes six ambulatory day treatment centers, an adolescent residential treatment center, and a separate short and long term reentry program.

In 1963, Daytop came into being as a pilot program treating hard-core heroin addicts. No distinction was then made between adolescents and adults, just as no distinction was made between minimal drug users and addicted users. A major shift occurred in the American drug revolution between the 70's and 80's that forced the TC to reexamine its policies and structures. The shift was basically one of population and drug preference. Polydrug abuse, not heroin addiction, became the dominant drug pattern, especially among the young. Daytop thus began to see a younger, more middle class population with more severe psychiatric profiles entering the therapeutic community. Many adolescents entering Daytop suffered from depression or were victims of incest or other forms of child abuse. A high percentage were children of alcoholics or drug abusing parents.

Development of Adolescent Ambulatory Care

TC's have been experiencing the impact of these shifts in American drug abuse patterns since the mid-70's. Because of the changes in drug use and style, we have had to adapt our treatment to the needs of younger more psychologically distressed, and family-alienated polydrug abusers.

Daytop's early experience with this population was a catalyst for our taking the major step of instituting an expansive day treatment program for drug-using adolescents.

By 1975, Daytop completed development of six adolescent ambulatory care facilities that now provide day treatment to a total of 370 adolescents in each of the five boroughs of New York City and Westchester County. Four hundred family members of these youngsters also actively participate in Daytop ambulatory programs.

The mandate of Daytop's outreach centers is to provide community-based day care for adolescents 13 to 19 who have minimal drug abuse problems. The centers work closely with the community to initiate prevention programs and other community service work such as Daytop's Elderly and School-Speakers Programs. Adolescents in our ambulatory program assist in community drug prevention efforts by discussing their personal drug histories and rehabilitation with school children their own age.

The peer principle, a critical recovery tool in treatment of these ambulatory center members, has proven equally successful when adapted to school prevention work. Adolescents in ambulatory treatment through the community service work of the centers benefit as much as they give as they experience the values and rewards of helping others. The ambulatory center-based Daytop CARES Program which provides meals and transportation to isolated and disabled elderly in Brooklyn and Queens is our proudest example of community service work benefiting both the community and our own adolescents.

Ambulatory Care: Programming and Philosophy

A typical Daytop ambulatory care stay averages 12 months. Length of stay varies, however, according to individual need. Whatever its duration, Daytop's ambulatory care for adolescents is participation by the adolescent in a highly structured day treatment environment which is divided into three segments:

1) Phase I is the integration of the new member into a positive peer support system that has proven to be one of the most powerful recovery tools of the therapeutic community.

2) Phase II focuses on in-depth psycho-social rebuilding. A foundation of drug-free behavioral stability and strong interpersonal and family relationships is established during this period.

3) Phase III concentrates on the social adaptation, educational, and vocational needs of members. Phase III activity emphasizes educational and vocational preparation; development of personal goals, and cultivation of social skills the adolescent will need outside of treatment.

Ambulatory care services include diagnostic screening and referral, physical examination, medical and dental treatment, positive peer support, group and individual therapy, family counseling, educational counseling and remedial course work, vocational counseling and placement, and recreational and cultural activities.

The hallmark of care provided with Daytop's Full Service Adolescent Programs is individualized treatment. Unlike programs with more limited resources, Daytop is able to follow up careful preliminary

diagnostic screening, matching the adolescent's individual treatment needs. Adolescents are not automatically assigned to residential treatment since outpatient care is available. Nor are they assigned to long-term residential treatment because short-term inpatient care is available.

Each adolescent in Ambulatory Care is assigned to a clinical staff member who becomes his/her primary counselor. An individualized treatment plan is then drawn up for the adolescent who receives one-to-one counseling. They participate in group therapy and attend school taught by certified teachers within the outreach center who are supportive, yet challenge the adolescent to improve past academic performance. This is to ensure the youngster's successful return to school in the community and help him/her grow in self esteem. Adolescents pursue formal education in Daytop's outreach centers, perform assigned work functions as part of practical, applied work therapy and participate in the rich cultural activities of the facility.

Parental participation is essential for success in treatment. In an outpatient day treatment modality, uninvolved family members can very easily destroy hard-won clinical progress. Faster progress in treatment is almost always made when the family is involved in their child's treatment through supervised family counseling and actively participate in their own peer groups within the Family association.

Daytop has found that involvement of the family is a strong positive influence promoting adolescent outpatient recovery. Those who do not receive positive family support will often be precluded from participating in outpatient treatment since their prospect for success is limited. These youngsters will be referred to 24-hour residential care.

Day Treatment Versus Residential Treatment

There are significant differences in the make-up of residential versus ambulatory care, as there are also noteworthy differences between the adolescents participating in the two treatment modalities.

Ambulatory as opposed to residential clients, however, typically receive a different kind and degree of family support. These clients more often are individuals whose home environment is supportive of their treatment. TC residents very often have home lives that are seriously disturbed. These youngsters are more often orphaned, abused, or the children of chemically dependent parents.

Another feature distinguishing our residential programs is the admissions criteria. Criteria for admission to adolescent residential treatment is addiction. Criteria for admission to ambulatory care is drug use.

Drug use warranting admission to a day treatment program is use which causes the youngster problems at home, work or school. Drug behavior is also often associated with involvement with a negative peer group and with the criminal justice system. Addiction, as opposed to drug misuse, is more frequently physical or powerful psychological dependency.

Considerable controversy has recently been generated concerning residential treatment for chemically dependent adolescents. There is much debate concerning the question of what constitutes appropriate treatment for drug-taking adolescents. Issues of minors' civil rights and the effectiveness of various residential adolescent treatment programs have been specifically raised.

The philosophy, policies, and operational procedures of Daytop's adolescent program address many of the currently disputed issues. They are the following:

* Daytop will accept no adolescent for residential treatment until he/she has had appropriate diagnostic assessment and screening.

* There are no locked doors within Daytop's system of treatment.

* Daytop's ambulatory centers are specifically designed to assist the youthful drug experimenter who has already experienced home, work, school or legal problems because of drug use. Daytop will work with this individual to help him/her avoid falling into a permanent pattern of addiction.

* Daytop ambulatory centers act as the agency's prevention and community service arm, as well as treatment unit.

* Adolescent TC residents typically, but not always, use more drugs and use drugs more regularly than do ambulatory members. Many have been unsuccessful participants in day care programs who have been referred to residential care as a treatment of last resort.

* Many, but not all, adolescents referred to Daytop's residential program have stronger drug abuse patterns than day care members.

* The most important single reason for referring a client to Daytop's residential program is lack of a stable and supportive family environment.

Residential Treatment for Adolescents

Early experience in treating a mixed adult and adolescent residential population convinced us that a separate therapeutic community was needed to enable us to deliver more individualized and effective treatment to adolescent drug abusers. These residents, we discovered, have specific treatment needs because their life stage experience and existential problems and goals differ considerably from those of adults.

Thus, in 1977, when the number of adolescents seeking residential treatment justified the step, Daytop opened Millbrook, a 70-bed upstate new York residential treatment center. Adolescent programming developed for Millbrook expanded the services already offered by Daytop. The fact that most adolescents in ambulatory care come from a relatively stable home, and will return to the same after completing treatment, has proven to be the single most important factor distinguishing adolescents in ambulatory care from TC residents.

Daytop established Millbrook to provide adolescents with treatment that addressed their specific needs to maximize their recovery potential. Although there are similarities between adolescent and adult substance abusers, there are critical differences. We instituted policies several years prior to release of 1985 data from the New York State Division of Substance Abuse Services on adolescent chemical dependency treatment. It is interesting that philosophy and operating procedures initiated by Millbrook substantially reflect major recommendations made by the State Drug Agency. The policies paralleling the State Agency recommendations include the following:

1) Millbrook provides residential chemical dependency treatment for youth that is voluntary, drug-free, that supports abstinence from both alcohol and drugs, and that is staffed by a multi-disciplinary treatment team.

2) The basic premise behind Millbrook is the need to provide specialized treatment for adolescents whose treatment needs cannot be satisfactorily met in either adult residential treatment, or in existing ambulatory programs.

3) Millbrook admissions criteria overlap suggested New York State Division of Substance Abuse Services guidelines in that it is Millbrook general policy to accept into treatment adolescents whose psychological or physical dependency on drugs impair them in an important life sphere, i.e., home, school or work.

4) Millbrook, as DSAS independently recommends, looks to family stability as an important determinant of the length of the adolescent's treatment stay. Those who have a reliable family support system usually leave residential treatment sooner than those who lack this support.

As family support is associated with length of stay in residential treatment, so is it also associated with whether the adolescent will be accepted for ambulatory or residential treatment.

Differing drug histories, greater problem drinking and more distressed psychological profiles of chemically dependent adolescents, in particular, point to a need for separate instead of combined adult and adolescent residential treatment. Profiles of chemically dependent adolescents more often indicate a need for comprehensive mental health services, alcohol education, and total abstinence, particularly for high risk children of substance abusers. Daytop has responded to these specialized needs with a program of intensive alcohol education for adolescent TC residents; a total abstinence ethos, and a specialized TC staff including certified teachers, sports directors, art therapists, etc.

Since a large proportion of adolescents will return to their natural or substitute family upon graduation, family therapy plays a more central role in their treatment. Preparation of both the adolescent and parents for realignment into a healthier family system at the end of treatment is one of the most critical aspects of his/her treatment.

Another difference between the adult and adolescent resident is the primary importance of the educational component in the treatment of the adolescent. The adult focuses more strongly on the work-related concerns especially critical during the reentry process.

Formal Education within the Adolescent Therapeutic Community

Millbrook offers residents excellent formal education specifically adapted to the TC structure at junior, high school and college levels. These educational programs attempt to teach more, however, than do traditional schools. Education is important in its own right but is also important clinically as adolescents gain increased self-esteem as a natural consequence of growing academic competence.

In addition to mastering academic subject matter, the adolescents learn values, a responsible concern for self and others, the rewards of creative work, cooperation and teamwork in learning, effective self expression, abstract reasoning and problem solving skills, and respect for self, others, the learning process, and intellectual disciplines mastered.

Behavior modification is a dynamic part of Millbrook's educational programming, as it is also an important aspect of other clinical programming. The adolescent students are rewarded for cooperation, a positive attitude toward learning, good study habits, good effort, and good academic achievement. Learning is not solely academic, but takes place on three basic levels -- academic, psychological, and philosophic.

The three levels interact synergistically to benefit the adolescent. Thus, the well-motivated responsible adolescent experiencing the satisfaction of academic achievement enjoys the complimentary bonus of increased self-esteem and general psychological well-being.

Millbrook strongly emphasizes education since adolescent substance abuse is significantly correlated with poor school performance and minimal study. The correlation suggests that the intensive formal education in therapeutic communities can lead to not only educational gains but also to gains in the adolescent's sense of self-worth that will support abstinence. Within Millbrook, as within Daytop's other TC's, therapeutic learning is primary and most critical. Our experience with formal education within the adolescent TC, however, clearly establishes the worth of academic learning as a therapeutic tool.

An important part of formal education at Millbrook which diverges sharply from traditional American educational practice is adaptation of TC values to academic learning. The residents work together cooperatively as a learning team. Unproductive academic competitiveness, which is often encouraged in the educational system outside the TC, is replaced by the peer process model which is the TC's central therapeutic tool. Use of peer tutors, peer role modeling and peer cooperation are stressed.

The pre-college course work provides appropriate education at the academic readiness level of the individual. It also serves as a bridge to other educational opportunities available within and external to the therapeutic community.

Daytop Miniversity is one of these opportunities. Through the Miniversity, selected older Millbrook residents are able to obtain undergraduate college credit applicable to the Baccalaureate Degree while still undergoing treatment at Daytop. Adolescents, like other Daytop residents who participate in the Miniversity program, typically show significant gains in self-concept including establishment of a more positive, reality-based self-image.

Vocational Training

Although vocational training is less emphasized within Millbrook than in the adult therapeutic community, residents are pretested for vocational aptitude at the start of their stay and later participate in two 14-week courses in one of the three following vocational areas: micro-computer/word processing, furniture restoration/rebuilding, or culinary work.

Vocational counselors work closely with the residents to help them shape and attain objectives. The vocational counselors also cooperate with the New York State Office of Vocational Rehabilitation staff to provide the adolescent with more comprehensive vocational skills training than the TC alone can provide.

Beyond any of its other functions, Millbrook is most basically a caring community and substitute family for adolescents displaced from the two most critical human institutions – family and community. Millbrook serves also as a symbolic halfway house bridging the initially great distance between the adolescent drug abuser and his/her healthy participation in society.

I believe that Millbrook's greatest healing strength and the basis of its treatment success is the quality and kind of second chance family that it offers to adolescents who have been abandoned physically or psychologically, and who are usually, themselves, self-abandoned and despairing.

To achieve the objective of serving as substitute family and caring community, Millbrook is structured so that each resident becomes a brother or sister to every other resident with each resident helping all others to grow into caring and responsible adulthood. A staff member who is assigned to each adolescent as his/her primary counselor provides individual and group counseling on a daily basis while also serving as a positive role model and parent figure.

In addition to participation in Family Milieu Therapy, all Millbrook residents receive the following formal family services:

* family assessment on intake
* family therapy
* counseling for individual family members
* crisis intervention and family counseling

All clients receive medical and psychiatric care as needed, acquire values education, attend daily house activities structured to provide a sense of community and enhanced individual identity, and participate in

recreational activities including art and dance therapy, team sports and group outings. All Millbrook residents also participate in group therapy in each of the following group modalities:

- encounter groups
- static groups
- topical groups
- peer confrontation groups
- pre-request and leave request groups
- health, hygiene and sexuality groups
- extended groups
- marathons

Specific educational and vocational services which are a standard part of Millbrook treatment include:

Stage I: Assessment - Vocational/Educational Levels: Vocational/Educational intake evaluation, standardized math and reading tests for placement in school program. High School Equivalency program, life skills training through the New York State Office of Vocational Rehabilitation, Vocational Training through the New York State Office of Vocational Rehabilitation, Vocational/Educational counseling for college placement, seminars and topic oriented workshops.

Stage II: Evaluation - Vocational/Educational Needs: Assessment by Certified Rehabilitation Counselor, retesting, successful attainment of educational goals appropriate to client's age, completion of Life Skills Training Program, successful completion of remedial course work necessary for placement in college.

Stage III: Placement - Vocational/Educational Programs: Attendance at school/vocational workshops, vocational/educational counseling, New York State Office of Vocational Rehabilitation referrals.

Work therapy, a form of behavior modification utilized in the TC, is structured so that residents receive progressively more responsible work assignments and are held personally accountable to all other members of the TC for successful performance of job functions.

Work therapy like other aspects of behavior modification therapy employed at Millbrook, emphasizes changing the maladjusted behavior as its primary goal. Clinical work to uncover and repair underlying causes behind the negative behavior is valued but will follow later. The basic premise of Millbrook's reward and denial behavior modification approach is that the adolescent will learn more healthy behaviors, and more positive values if there are always positive and negative consequences attendant on behavior.

Millbrook was established essentially because the concept of the therapeutic community as a dependable, highly structured and involved second chance family cannot find full expression outside of 24-hour residential treatment. This is the most important factor distinguishing Daytop residential from ambulatory treatment.

Adolescent Reentry Component

As staff began to see that adolescents have specialized reentry needs which differ from those of adult residential clients, a reentry program was added to Daytop's other adolescent services to accommodate these needs.

A specialized adolescent reentry unit was also developed as a response to the changing charade of entering clients and of their parents. The program thus had to adapt to the needs of younger clients who required supervision not available in their homes. Daytop has also had to adapt to the adolescents' parents who often were children of the flower power and drug experimentation times of the 60's. Grown into adulthood, the parents often have not been able to maintain two-parent family or to end their own drug use.

Daytop established its adolescent reentry unit so that adolescents in the therapeutic community are not forced to return directly to an unhealthy family setting diluting treatment gains and setting a tone for ultimate treatment failure.

Adolescents with a healthier family support system were seen to benefit from a short-term residential reentry period cushioning the cultural shock of reintegration into the community. The peer support offered by the program has proven valuable in cushioning reintegration into the community and also in achieving the social, academic, and vocational goals of the adolescents in the unit.

Concurrent with opening of the reentry unit, we established a procedure requiring evaluation of all adolescents completing residential treatment to determine whether the individual would benefit more from a reentry stay or immediate transfer to a Daytop ambulatory unit.

Although the decision to rotate a resident to reentry or to an ambulatory center is made on an individual basis, there are generally three kinds of adolescent residents who are rotated from Millbrook:

1) Those in need of short term reentry after which time they will be transferred to an ambulatory center for aftercare and back to their parental home;

2) "Standard" adolescent residential clients who are rotated to reentry as part of an orderly progression of treatment which will in time lead to graduation; and

3) The very hardest to treat and to service individuals who are in need of long-term reentry due to their age and/or inability to ever return to living with their family of origin due to either family disorganization, drug abuse, or to physical and mental abuse of the child.

While Daytop's adult reentry program is more strongly focused on return to work, the reentry program has as its prime focus successful return of the adolescent to the family and community school system. The two reentry programs also differ in that the length of an adolescent's stay in reentry is strongly influenced by degree of family involvement in his/her treatment. Reentry residents whose parents actively participate in treatment generally leave reentry sooner than adolescents whose families are less involved. The length of an adult's reentry stay, however, is primarily determined by individual, not family, factors.

Adolescent reentry is also distinguished from adults by the fact that they generally stay in residential care for a shorter period of time. Adolescents in reentry require greater structure, support and supervision than adult clients who are older and capable of greater independence. Adolescent reentry is more highly structured. They still have their treatment supervised by one primary staff member and participate in a more structured clinical and cultural program.

Another factor distinguishing adolescents from adult reentry is the need for placement that many adolescent reentry members have. Adults are expected to leave the therapeutic community and lead an independent life. Many adolescents who complete the adolescent reentry program, however, do not have a viable home to return to or are too young to live independently.

Conclusion

We who have dared to assume the role of substitute parents to the youngsters in our care find that with great intensity they want to learn if we are only the nurturers they know or whether we are also active and instrumental figures. Are we potent and reliable enough to successfully protect their interest in an uncertain world? As we monitor their growth and development, so do they monitor ours.

The first question posed is whether we in the therapeutic community have the requisites and creativity to make whatever changes are needed to keep programs alive and well financially and effective as treatment tools.

Can we cut whatever ties we must with our social service history?

Can we become possessive to the extent that the survival of the therapeutic community depends on this and yet ensure that treatment, our true business, is not compromised?

Are we capable of building bridges of successful cooperation with alcohol agencies to successfully treat a common problem?

Can we, by cooperating with alcohol agencies, establish dual licensing and funding initiatives that will bring us closer to success in attacking one grave problem?

We must be successful at all of these tasks. For it is only from the basis of this success that we may ensure a future for the therapeutic community and expeditiously fulfill the honorable, enormous, and responsible role that we have assumed as guardians for adolescent children in treatment within the therapeutic community.

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ADOLESCENT SUBSTANCE ABUSERS IN THE TC: TREATMENT OUTCOMES

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ABSTRACT

Post treatment outcomes are reported for a sample of a 1974 cohort of adolescent and adult substance abusers in a traditional therapeutic community. Data are presented both for voluntary and legally referred clients. The main findings reveal that a) legal referrals were proportionately higher among adolescents; b) regardless of age or legal status, the entire sample showed a considerable degree of criminal involvement; c) as expected, younger clients and voluntary referrals reveal less criminality, although juvenile history of crime was significantly highest among legally referred adolescents (under 19 years of age); d) age did not significantly relate to post-treatment outcome. Success rates were statistically similar for adolescents and adults. However, legally referred adolescents who dropped out of treatment yielded fewer favorable outcomes. Nevertheless, the evidence indicates that the TC exerts a positive impact on these more recalcitrant groups of adolescents.

INTRODUCTION

Substantial literature points to the effectiveness of the therapeutic community (TC) approach in rehabilitating substance abusers (see recent reviews by Bale, 1979; Brook and Whitehead, 1980; De Leon, 1984; De Leon and Rosenthal, 1979; Sells, 1979). Significant improvements occur on separate outcome variables (drug use, criminality and employment) and on composite indices for measuring individual success (e.g., De Leon, et al., 1982). With few exceptions, followup studies report a positive relationship between time in program and post treatment outcome status (see Figure 1). Generally, these findings have been obtained on program-based studies of individual TCs (e.g., Barr and Antes, 1981; De Leon, 1984; Holland, 1982). However, they have been corroborated in larger scale externally based followup studies of various modalities that include therapeutic communities (e.g., Simpson and Sells, 1982).

The recent decade has witnessed a marked increase in adolescent substance abuse. Despite a slowing of this trend in the last three years, the prevalence and the range of youthful drug use is greater, and the age of first use is lower than that seen ten years ago.

Adolescents comprise approximately 20-30% of admissions to drug-free residential settings, such as TCs (CODAP, 1979). Almost a third of these are referred to treatment through the Criminal (juvenile) Justice System.

However, relatively little is known about the efficacy of different treatment modalities for these adolescent clients and less is understood about the effectiveness of treatment for adolescent substance abusers who have been involved in the criminal justice system. For example, a recent volume reviewing youth drug abuse contains only two studies of treatment effectiveness (Beschner and Friedman, 1979).

In these studies conclusions about treatment effectiveness for the adolescent remains somewhat unclear for several reasons. First, the adolescent samples followed were drawn from different treatment modalities and program. Program effectiveness may vary particularly within the therapeutic community modality. Differences in clients served, philosophy, resources and clinical and management experiences, as well as success criteria, all contribute to program variability. Second, one study did not include post treatment outcomes. Additionally, there were other methodological weaknesses which render the findings from this effort somewhat tentative. Third, the other study (i.e. DARP) did not provide a single composite index of individual success with respect to age differences. This is important for traditional therapeutic communities whose primary treatment aim is a global change reflected in elimination of antisocial behavior, illicit drug abuser as well as enhancement of productivity. Fourth, and perhaps most importantly, these outcome studies have not focused on adolescents who were legally involved or referred to treatment from the juvenile justice system.

The above considerations shaped the general purpose and design of the present research. A brief description is provided of the criminal background characteristics of two subgroups of adults and adolescents, volunteers and those legally referred to treatment in a traditional therapeutic community. Post treatment outcomes for these groups were obtained with a composite success index of individual change.

METHOD

The Traditional TC

There are more than 500 federally supported, drug free residential settings in the United States (Holland, 1982). Not all of these are therapeutic communities (TCs) and, among the subset of those termed

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There are more than 500 federally supported, drug free residential settings in the United States (Holland, 1982). Not all of these are therapeutic communities (TCs) and, among the subset of those termed therapeutic communities, approximately 25% are of the traditional long term variety, such as Phoenix House.

These programs are similar in planned duration of stay (15-24 months), in staffing pattern, and in rehabilitative regime, although they differed as to size and client demography. Clinical staff are a mixture of degreed and nondegreed professionals. Often, the majority of the clinical management staff are ex-offenders and ex-addict/substance abusers who themselves were rehabilitated in the TC programs. Support staff generally consist of degreed professionals in health services, fiscal administration, legal, vocational-educational and family counseling. The clients include criminal offenders and the socially displaced, adults and adolescents whose primary presenting problem is substance abuse.

The perspective of the traditional TC on drug abuse and its recovery has been described in other writings (De Leon, 1981; De Leon, 1984; De Leon and Beschner, 1977; De Leon and Rosenthal, 1979; Kaufman and De Leon, 1978). Fundamental to the TC approach is the necessity for a total 24-hour residential community impact to modify lifelong destructive patterns of behavior. The basic goal is to effect a complete change in the lifestyle: abstinence from illicit drug use, elimination of antisocial behavior, development of employable skills.

Residents move through explicit phases that are sequenced to provide incremental degrees of learning, both psychological and social. Generally, there are three main phases: early (0-3 months), primary treatment (4-12 months), and reentry (13-24 months). The daily regime is structured to keep the resident fully involved in a variety of work, educational, therapeutic and recreational activities. Some key treatment components include group therapy, individual counseling, tutorial learning sessions, remedial and formal education classes, and client job functions.

Adolescents and adults in traditional TCs undergo the same basic regime in treatment process. However, there are modifications in the TC approach which acknowledged distinctions among substance abusers which have been identified primarily through clinical observations and some research (see for example, De Leon and Deitch, 1984; Holland and Griffen, 1983). These primarily emphasized the normal developmental needs of adolescents. For example, the importance of education, family involvement, guiding social and sexual role identity, etc. A further account of the therapeutic community approach for the adolescent is provided elsewhere (De Leon and Deitch, 1984).

The Sample

A full description of the followup study is contained elsewhere (De Leon, 1984). This section briefly summarizes the essential methodological elements.

The 1974 cohort (N=424) consisted of male and female dropouts (N=371) and graduates (N=53) who were mainly black, and 19-26 years of age. Fifty-three percent were primarily involved with amphetamines or barbiturates (primary "other"), and 5 percent claimed no primary drug of abuse.

The 1974 dropouts were a 37% sample of the entire residential population randomly drawn from six continuous time in program (TIP) groups (less than 1, 1-4, 5-8, 9-12, 13-16, and 17+ months). With the exception of the largest (17+) group, each TIP group was of similar size but represented a varying percentage of the TIP proportions of the residential population. Graduates (N=53) were a 52% sample of those who completed the program in 1974-75.

Criminal Profile. Since legal referral was a variable in this study the criminal profile of the entire sample was analyzed by age and legal status. Criminal involvement is significantly higher among older clients regardless of those with a legal status. The clients over 27 reveal significantly higher total arrests, total convictions, drug arrests and drug convictions when compared with the two groups under 27 years old which are generally similar. These age differences are more pronounced for the oldest clients with a legal status whose criminality was significantly higher than all other subgroups by age or entry status; Juvenile criminality, in terms of total arrests and age of first arrest is worse among the younger clients, particularly those with a legal status.

not described. The survey contained over 225 items, binary or scaled rating, that focused upon four main temporal periods: 1) Background - family, social, personal, drug and criminal history in the years prior to Phoenix (lifetime); 2) Pre-Phoenix - month by month tracing of life activities in the year before entry into Phoenix; 3) Phoenix experience - the client's expectation and perception of treatment benefits, significant treatment influences, staff and peer relations, and reasons for termination; 4) Post-Phoenix - month by month tracing of life activities, e.g., drug use, drug and other treatments, criminality, employment, and social and personal relations across all the years of followup.

Entry Status. . There were two classifications of entry status: 1) legal status-clients referred to treatment directly through the criminal or juvenile justice system, typically including individuals who are probated, paroled, or otherwise court mandated to treatment; and 2) non-legally referred (voluntary status) -- those clients whose source of referral did not directly involved the criminal or juvenile system.

There are caveats concerning these entry status classifications. Legal status clients may actually choose treatment on a voluntary basis since this may be offered as an option for them. Conversely, voluntary clients may seek treatment under existing or anticipated legal pressure, such as a court case, the presence of warrants, etc. Thus, the classification is employed to grossly distinguish two groups of clients by their primary route of referral.

Similarly, the labels do not precisely identify differences in motivation for treatment nor do they necessarily correlate with the clients' perception of legal pressure. Legally referred clients may vary in the degree to which they experienced anxiety, pressure or fear of legal consequences. Later analyses will assess motivation or experienced pressure to change among both legally referred and non-legal referrals.

A minority of the followup sample entered Phoenix House with a legal status. Significantly more graduates were legally referred than dropouts. Legal status decreased linearly and significantly with age and, reciprocally, the percentage of volunteers increased with age (Figure 2).

Success Rates by Age and Legal Status

Success, in the TC, is a shorthand term describing the essential clinical goals of prosocial behavior and freedom from drugs. Thus individual social adjustment was measured with three composite indices derived from 16 separate variables in the domains of criminality, drug use, and employment.

The Criminal Index (CrimDX). If there was at least one episode of criminal engagement, arrest or at least one week spent in jail during any month of observation, the CrimDX was scored for the entire year and for all cumulative years.

The Drug Index (DrugDX). A DrugDX was scored for all clients if there was a) any use of any opioid (heroin, methadone, dilaudid, or other opioid) irrespective of the client's primary drug pretreatment ç or b) any use of the primary drug, opioid or nonopioid. For clients who reported no primary drug pretreatment, a DrugDX was also scored if there was any use of glue, hallucinogens, hypnotics, or weekly use of marijuana or alcohol, or use of other nonopioids single or in combination, at least 3 times in 1 month. Again, a DrugDX in any month resulted in a DrugDX for the entire year and for all cumulative years.

The Success Index. Weighted combinations of the CrimDX and DrugDX placed the client on a 4-point scale of favorable status. Criminality was judged more negative than drug use in the rating. Employment was excluded from the 4-point success index for empirical reasons. A 12-point index correlated above +0.90 with the 4-point scale, indicating that this addition did not significantly change the client's relative status. The 4-point success index was defined as follows:

Success #4, Most Favorable Status: No occurrence of a CrimDX and no occurrence of a DrugDX through all months of observation.

Success #3, Favorable Status: No occurrence of a CrimDX through all months of observation, but at least one occurrence of a DrugDX.

Success #2, Unfavorable Status: No occurrence of a DrugDX through all months of observation, but at least one occurrence of a CrimDX.

Success #1, Most Unfavorable Status: At least one occurrence of both a CrimDX and a DrugDX either separately or together in any month of observation.

There are temporal requirements that entered in the Success Index. The lowest Success Index in any year was the index for all cumulative years. Conversely, a best Success Index (#4) had to be maintained for all cumulative years. An index less than best was included in the results irrespective of the minimum requirement for time out of program (TOP). However, best successes were excluded if they could not meet the TOP requirement. These criteria represent Phoenix's austere requirements for success. However, they generally accord with the conservative view of clinical success in other traditional TCs.

Time at risk (TAR) was defined as TOP minus months in jail. TAR entered into the construction of the success index. Jail time was automatically scored as a CrimDX. Also, a DrugDX was scored if the client

Table 1

Success at 2 Years Followup:
Age and Legal Status (a)
Males

		Legal		Voluntary		Totals	
		N	%	N	%	N	%
<19 Years							
Success	4 (b)	6	33.3	3	30.0	9	32.1
	3	1	5.6	4	40.0	5	17.9
	2	2	11.1	0	0.0	2	7.1
	1	9	50.0	3	30.0	12	42.9
10-26 Years							
Success	4	19	39.6	26	44.8	45	42.4
	3	6	12.5	14	24.1	20	18.9
	2	8	16.7	5	8.6	13	12.3
	1	15	31.2	13	22.4	28	26.4
27+ Years							
Success	4	4	30.8	15	33.3	19	32.8
	3	1	7.7	11	24.4	12	20.7
	2	3	23.1	5	11.1	8	13.8
	1	5	38.5	14	31.1	19	32.8
Totals							
Success	4	29	36.7	44	38.9	73	38.0
	3	8	10.1	29	25.7	37	19.3
	2	13	16.5	10	8.8	23	12.0
	1	29	36.7	30	26.5	59	30.7

(a) Percents may not add to 100.0 due to rounding.

(b) Success 4: Most favorable (no crime and no drug use)
3: Favorable (drug use, but no crime)
2: Unfavorable (crime, but no drug use)
1: Least favorable (crime and drug use)

(c) Positive change from pre-treatment distribution of success index is statistically significant. The actual proportion of individuals who changed is more clearly shown when absolute success status is ignored. Almost 84% of the sample had the lowest success index (Index 1) for the year prior to treatment. Positive change over pre-treatment levels occurred in almost 60% of the sample and was significant by age and legal status with the exception of the youngest legally referred clients. They showed the smallest reduction in change for clients with the lowest category.

failed the drug use criteria while in jail. Time spent in other drug treatment settings, however, was considered a risk, although some investigators have argued otherwise.

RESULTS

Success Rates. Table 1 shows the distribution of the success index by age and legal status. The data on females are excluded since there were few women under 19 years old with a legal status. The results in Table 1 may be summarized as follows. The overall success rate (percentage of Index 4) for the sample is 38.0% and did not differ significantly by age (last column) or legal status (last row). However, clients in the middle age range (19-26 years of age) yielded more successes, regardless of legal status.

When dropouts and graduates are separated, differences appear, particularly by legal status. Legal referrals were significantly higher among graduates (57.1% vs. 34.9%), a difference that occurred at every age; and graduates yield a significantly higher success rate than dropouts (66.7% vs. 32.7%). This graduate/dropout difference persisted across age and legal status.

Among dropouts, however, outcome appears to be related to both legal status and age, although differences were not statistically significant. Higher success rates were obtained for the clients 19-26 years old (42.3%) when compared to the youngest (22.7%) and the oldest clients (28.9%); among the latter two groups, more success occurred for voluntary clients.

Some Correlates of Success

The relationship between success rates, legal status, age and other client correlates were further examined through hierarchical and regression analyses. In these, predictor variables were entered in a fixed order corresponding to a theoretical conception of their hierarchical position. The first set of variables was race/ethnicity, primary drug of abuse and age at entry; legal status on admission was entered next followed by an age-legal status interaction variable. (Interaction variables in linear regression models have been challenged by other investigators.) The last entries were pretreatment success index and time in program. The latter was assumed to be correlated with treatment influences and deliberately entered last to evaluate its contribution after the effects of the other variables were removed. There were no exclusions based on risk factors since few clients were confined in jails or hospitals during the 2 post-treatment years. Regressions were carried out for the male dropouts only since the inclusion of the graduates would have biased the weight of the time in program variable.

Higher success through two years of followup was related to primary opioid abusers, voluntary clients, and longer time in treatment. Notably, the age-legal status interaction variable was not significant in the regressions.

Based upon the significant regression findings, the 4-point distribution was examined univariately by primary drug of abuse, age at entry and legal status. Among dropouts, opioid abusers showed significantly more best successes than non-opioid abusers (46.9% vs. 10.9%), a difference that persisted across age and legal status. Regardless of primary drug, a higher proportion of least favorable outcomes occurred among the younger clients with a legal status. However, the oldest non-opioid abusers with a legal status also contained a high proportion with least favorable outcomes.

Among graduates, success rates were uniformly high by age, legal status and primary drug. Notably, all of the young graduates who were primary opioid abusers with a legal status achieved best success status. When dropouts and graduates are pooled, the success rates for the youngest opioid abusers with a legal status elevates and exceeds those for the clients over 19. Thus, the relatively higher proportion of least favorable outcomes for the under 19 year old clients is confined to the dropouts with a legal status.

Success and Time in Program. The regression results indicate that time in program remained the most significant predictor of successful outcome. Prediction of time in program itself has been examined in multiple regression studies reported elsewhere (De Leon, 1983). In these, age, legal status or race did not significantly relate to retention, although primary opioid abusers yielded significantly longer days in treatment than primary non-opioid abusers. Notably, univariate analyses revealed no significant differences in mean days in treatment by legal status within each age group. Thus, although success overall increases with retention in treatment, the relatively high proportion of least favorable outcomes among the youngest dropouts did not relate to their time in program.

In summary, favorable outcomes were significantly higher for graduates, primary opioid abusers and voluntary clients. Age overall did not relate to favorable outcome. However, those in the middle age range had more successes and least favorable outcomes were more frequent among the youngest clients with a legal status regardless of primary drug. This finding was true for dropouts only. The inclusion of graduates reduced the proportion of poor outcomes and significantly elevated the success rates for the legally referred young opioid abuser.

Finally, among the dropouts, the relationship between time in program and success is prominent among the opioid abusers particularly in the middle age levels. Outcomes for the oldest and youngest clients are less clearly related to length of treatment; in particular, the relatively higher proportion of least favorable outcomes among the youngest dropouts with a legal status is not related to their length of stay in treatment.

COMMENT

Favorable outcomes were more frequent among volunteers, however, evidence indicates that the impact of treatment does not appear to be substantially different by entry status: a) best success rates were not statistically different but the distribution was significantly more favorable for the volunteers; b) although successful, a considerable number of volunteers had criminal histories that were not significantly different from legally referred clients; c) conversely, over 70% of the graduates entered treatment with a legal status most of whom achieved and maintained best success levels.

Success rates were significantly higher for primary opioid abusers regardless of legal status or age. As reported elsewhere, this primary drug difference in part reflected the rather austere criteria for success in TCs which prohibited use of opioids or a non-opioid primary. Relatively few marijuana and alcohol abusers achieved abstinence from their primary drug. Thus, most could not be classified as best successes although many had eliminated their criminal activity and/or showed significant reductions in the frequency of use of their primary drug (see De Leon, 1984).

Figure 1

PHOENIX HOUSE
AGE AND LEGAL STATUS
(1974 Followup Cohort)

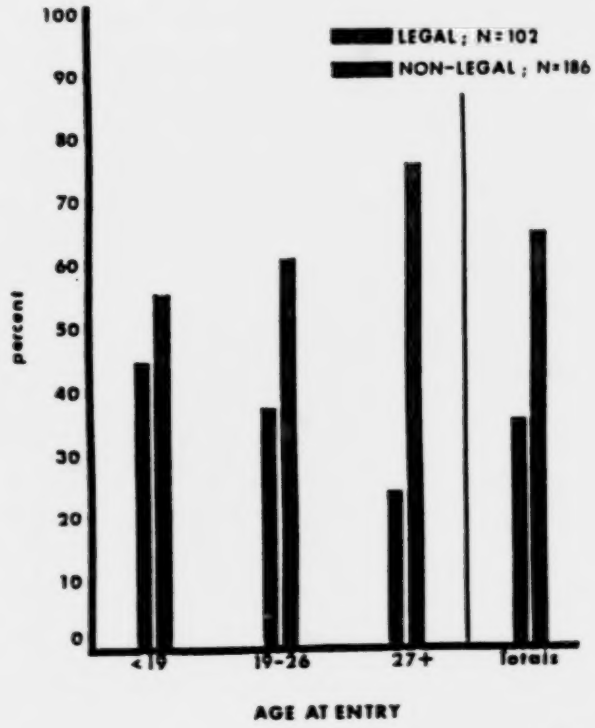
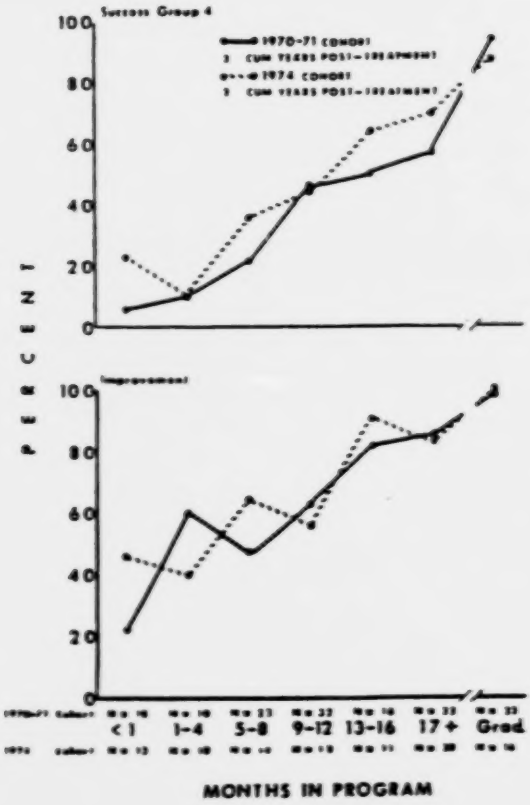


Figure 2



Age did not significantly relate to outcome. Best success rates were statistically similar across age and the regression analysis indicated that there was no interaction between age and entry status with respect to outcome. However, legally referred adolescents yielded less favorable outcomes, a result which is not yet well understood. Although time in program was the most significant predictor of success, outcomes among the young dropouts did not relate to their length of stay in treatment. Moreover, among all graduates, the proportion of legal referrals and success rates is significantly higher than dropouts.

Thus, there appears to be a subgroup of adolescent dropouts whose criminal background is similar to graduates but who continue to use drugs and commit crime regardless of their time in treatment. Other characteristics which may differentiate this group remain to be investigated.

Notwithstanding the above, the present adolescent findings are particularly impressive in light of the following points. First, the therapeutic community serves a more difficult or recalcitrant group of adolescents in comparison to outpatient settings. This is evident in the criminal profile results (not reported) for both the legally referred and voluntary clients whose criminal histories are significantly worse than those reported in the national survey sample of adolescent clients in federal drug treatment systems. Second, there is the common view that antisocial behavior and drug involvement tends to accelerate in the period from adolescence to young adulthood and tends to weaken in older clients; these age changes are presumably maturational. In the present findings, the better success rates among the older clients may in part reflect these hypothesized age related effects, although the relationship between time in program and success rates among clients over 19 points clearly to the influence of treatment.

Thus, the evidence indicates a significant treatment impact upon the adolescent clients in the sample. Best success rates, although lower, did not differ significantly from older clients; and the improvement from pre-treatment level in global status was significant, indicating a measurable reduction in their overall criminality and drug use.

Finally, the present findings firmly establish a relationship between residency in the TC and client status at followup. Conclusions concerning treatment effectiveness, however, must be interpreted in light of methodological and other considerations. For example, the validity of inferences about treatment is limited by the lack of control groups. The followup sample may be self selected to seek, remain in and benefit from treatment. Statistical regression and behavioral cycle hypotheses could be advanced to explain the observed changes over time; similar other possible influences in client status are drug treatments after Phoenix, social climate factors concerning criminal enforcement and drug traffic, as well as maturation and other as yet undetected client factors. As discussed elsewhere, these factors did not appear significant relative to the impact of treatment in the TC (De Leon, 1984).

CONCLUSION

Overall, the findings indicate that adolescent outcomes are not unlike those of adults. Under the rigorous outcome criteria employed in TCs, the success and improvement rates obtained are impressive regardless of age or legal status, although more graduates, volunteers, long term dropouts and primary opioid abusers yielded favorable outcomes. Fewer successes were obtained among the more antisocial young clients who were referred with a legal status. Nevertheless, evidence indicates that the TC exerts a considerable impact on this most recalcitrant group of adolescents.

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THE CHILD ABUSE - DELINQUENCY CONNECTION: IMPLICATIONS FOR JUDICIAL AND TREATMENT PERSONNEL

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This paper reports on the author's research on the relationship between child abuse and delinquency, summarizes the larger abuse-delinquency literature, and discusses policy aspects of the relationship.

Sandberg's Research

The project, entitled "The Role of Child Abuse in Delinquency and Juvenile Court Decision-Making" and funded by the National Center on Child Abuse and Neglect, was conducted in 1982-83 by a multidisciplinary team of research and direct service people. The project examined four issues: a) the prevalence of abuse/neglect among 150 delinquents referred to Odyssey House in Hampton, New Hampshire over the period 1974-82; b) whether specific kinds of abuse consistently lead to specific kinds of later delinquency; c) psychiatric implications of the abuse-delinquency relationship; and d) the feasibility of amending state delinquency codes to require an assessment for child abuse/neglect as an integral part of the pre-disposition social history.

Stages 1 and 2 were empirical in nature and carried out under the leadership of Dr. Murray Straus. The major findings were as follows:

1) Of the 150 delinquents (defined as a criminal offense if committed by an adult), 98 or 66% were identified as abused or neglected based on Odyssey House's medical/psychiatric records. Only residents whose maltreatment was pervasive and sufficient to warrant a finding of same under a preponderance of the evidence standard were coded "abused." "Neglect" and "emotional abuse" were construed very narrowly by the project.

2) 61% of the 99 boys studied and 75% of the 51 girls had been abused.

3) Physical abuse was by far the most common (53 of 99 boys, 32 of 51 girls). Next most common was sexual abuse (4 of 99 boys, 19 of 51 girls).

4) Over half of the abused group (54 of 98) experienced multiple abuse, meaning the same type of abuse at the hands of more than one parent and/or two or more different types of abuse.

5) The mean age of onset of abuse was seven (7), with only 10% of the abused group experiencing abuse that commenced in adolescence.

6) The average severity of physical abuse was 2.4 (out of 3), indicating that on the average the physically abused children in the study were very seriously assaulted.

7) Only a small number of the 98 abused youth had been identified as abused prior to entering treatment under court order.

8) Families of the abused group were typically multi-problem families, e.g. almost half of the abused youth had parents who were violent to one another, double the rate for families of non-abused children.

9) No significant relationship was found between specific types of abuse and specific types of later delinquency.

10) No significant relationship was found between specific types of abuse and later assaultive behavior, including no correlation between severe abuse and violent delinquency.

11) Members of the abused group were not involved in more crimes or more serious crimes than members of the non-abused group.

Following the empirical analysis of the 150 Odyssey House residents, then (10) additional youth were selected for case histories developed by the program's psychiatrists, Drs. Rowen Hochstedler and Judianne Densen-Gerber. The intent was to pursue analysis of the child abuse-delinquency relationship along psychiatric rather than sociological lines which thus far has not advanced much beyond prevalency rates.

These psychiatric members of the research team identified several paramount concerns associated with the child abuse-delinquency relationship. One, of all the problems commonly associated with delinquent youth, child abuse has the most devastating development impact. Two, the physically abused children reveal major confusion over nurturance and violence in interpersonal relationships, and the sexually abused children have major confusion over what is nurturance and what is sexual exploitation. The latter may

explain why the three (3) case histories involving childhood sexual abuse also feature later teen prostitution. Three, minor delinquency does not necessarily mean an absence of abuse, rage, and the potential for violence. And four, most of the case histories involve youth with matricidal/patricidal feelings.

Both psychiatrists articulated the view that identification and remediation of child abuse are essential prerequisites for many delinquents to avoid later criminality and/or other dysfunction in adulthood.

The fourth and last stage of the project involved an extensive assessment of the juvenile justice system nationally to determine the presence of any "systems" responses to the child abuse factor in delinquency cases. Only two were found (dicta by the West Virginia Supreme Court suggesting that juvenile trial courts should look for abuse histories prior to certain dispositions, and New York's conversion law which enables a judge to convert a proceeding for delinquency or CHINS offense into one for abuse). Given such a low level of awareness, the project urged that much more attention be given to the subject.

The legal members of the team also concluded it was legally defensible (and desirable) for each state to amend its delinquency code to require abuse probes prior to disposition. Only in this manner are courts apt to uniformly give attention to a critical factor in the lives of many delinquents.

In concluding its analysis, the project recommended that the abuse factor not be considered until after the adjudicatory phase of delinquency proceeding, to dispel any concerns that giving more attention to the abuse will result in excusing delinquent behavior. Moreover, project members emphasized that courts should always carry out a twofold responsibility to juvenile offenders: hold them accountable for illegal behavior and ensure that treatment referrals are made on the basis of specific rather than general information.

The Larger Child Abuse-Delinquency Research Literature

The Sandberg research is the most recent in a small number of studies going back to the early 1970's, nearly all of which show a high incidence of child abuse among delinquent populations. Three of the more often cited studies are briefly noted here.

1) Dr. Weston's Philadelphia study (unpublished) of 100 juvenile offenders, of which 82 were abused as children. 43 recall being knocked out by their parents.

2) Hopkins' Denver study (also unpublished) of 100 juvenile delinquents, of which 84 were abused before entering school. 92 were bruised, lacerated or fractured by a parent within a year and a half prior to their arrest for delinquency.

3) Jose Alfaro's New York study (published in Exploring the Relationship between Child Abuse and Delinquency, editors R. Hunter and Y. Walker) of over 5,000 children whose families were reported for suspected abuse in the 1950's, and 2,000 children who were reported for delinquency or status offenses in the 1970's. Children in the former group were traced ahead to learn of later contacts for delinquency, the latter traced backwards to learn of earlier contacts with a child protection agency. With both samples, Alfaro found contact rates as high as 50% in some counties.

A detailed analysis of the child abuse-delinquency literature was carried out in 1984 by Professor James Garbarino of Pennsylvania State University (Child Maltreatment and Juvenile Delinquency: What Are the Links?, unpublished). His conclusions include:

1) A significant relationship does exist between child abuse and delinquency, especially when the former is defined broadly and the latter narrowly;

2) How there two phenomenon relate, including causation elements, has yet to be determined;

3) Comparing studies is problematic due to researchers using differing definitions of "abuse" and "delinquency" or failing to define them;

4) Most of the studies are limited by the absence of a control group;

5) Data on the relationship between physical abuse and violent delinquency is sparse, but findings (mainly Alfaro's) indicate an association may be present;

6) "Our meager knowledge in this area is a promise of future understanding. Our ignorance is a challenge to researchers and policy makers alike."

Policy Considerations of the Abuse-Delinquency Relationship

Notwithstanding our "meager knowledge" concerning more complex aspects of the relationship, we know the single most important thing about the child abuse-delinquency connection: namely, there is one and it is significant. This alone is sufficient to compel major activity within the policy and direct service

communities. The remainder of this paper will briefly identify several such activities the author believes are especially needed.

Amend delinquency codes. Only in this manner will juvenile courts uniformly become aware of the child abuse factor among many young offenders. Wyoming now has such a statute which requires predisposition reports to include information on several state-of-the-art factors, including child abuse, learning disabilities, and physical impairments. There is no guarantee courts will make informed dispositions with this information, yet its presence makes appropriate placements more likely. It will also lessen any tendencies to overuse reform schools.

Train mental health workers. This includes therapeutic communities whose programs feature outpatient or inpatient units for adolescent offenders. Specifically, staffs to be effective today require training in such things as proper diagnostic/assessment protocol, generic stages of treatment for abused persons, and defusing rage. Similarly, given a high rate of learning disabilities among delinquents, programs also need to have a special education capability. Both problems necessitate family therapy skills as well as an aftercare program.

Earlier interventions. Although therapeutic communities working with adolescent and adult offenders will always be assured of an ample client case load, it behooves us to become involved in other intervention points along the acting-out continuum. Particularly important are efforts within the schools, as early as the elementary school years. To be more effective early intervenors, schools will need the assistance of courts and therapeutic communities, with their years of experience in dealing with behavioral problem youth. In light of the growing awareness about the abuse factor in acting-out, we need to stand behind educators in the effort to identify and remediate abuse as early as possible.

Conclusion

There are recent encouraging signs that the child abuse-delinquency issue is moving from the research community into the policy arena. In addition to Wyoming's 1984 amendment, the states of Delaware and Colorado are currently developing policy initiatives. Moreover, many key legislators have recently been briefed on the issue through seminars organized by the National Conference of State Legislatures in Denver. Especially noteworthy is the current effort by the American Bar Association to bring greater awareness of the issue to the legal community.

Beyond these undertakings and the policy initiatives called for here, it will eventually be necessary to add new curriculum to our schools of law, medicine, social work and psychology. Adolescent care has historically received too little attention in the United States, but the persistent problems of delinquency and child abuse, in particular, appear to be stimulating significant new attention to acting-out children.

THE THERAPEUTIC COMMUNITY AS A MODEL FOR EFFECTIVE ADOLESCENT LEARNING

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Treating young people during adolescence has always held special interest and challenge for the therapeutic field. Not only is adolescence a period of drastic physiological, social, and psychological change, but it is also a period of critical influence on the unleashing of the potentialities of young people for maximum self-realization and productivity in later life. Practically half of mental growth occurs during adolescence. In the therapeutic community field we not only have the opportunity but the obligation to provide an environment that facilitates self-actualization of the adolescent through development of cognitive, social, emotional and physical skills. It is my belief that the therapeutic community model accomplishes this task with adolescents in a way that no educational institution or other treatment model can.

Let us look first at the theoretical reasons why the therapeutic community model works educationally for adolescents. Throughout this discussions, keep in mind this premise: I believe adolescents have special needs within the therapeutic community and should not be treated as mini-adults.

I have compiled a list of elements which help explain the process through which a person learns. As I go through the elements of learning theory, I will discuss the relevant elements of the therapeutic community model in an effort to emphasize why the therapeutic community model works effectively with adolescents. This learning theory model was developed through the research of Dr. Stanchfield, Professor, Occidental College, Los Angeles.

Motivation

I believe motivation is essential and central to learning. I view motivation as: 1) energizing, activating and sensitizing the organism toward certain stimuli; 2) directing behavior toward certain goals; and 3) reinforcing behavior that is effective in the attainment of desired goals. In a therapeutic community, factors that should be used to motivate learning are:

1. *Contagion.* The mental health and attitude of the counselors, therapists, teachers, group leaders is extremely influential, or contagious on the client. The power of role-modeling is an essential element in motivating adolescents to change.

2. *Expectancy.* Expecting clients to change, learn and achieve goals successfully has a substantial effect on attaining the desired behavior from the client. This is the self-fulfilling prophecy. Clients tend to behave the way we expect them to behave. In the therapeutic community model, the community or group expectations are especially powerful with adolescents.

3. *Effectance.* The ability of an organism to cope with a test affects his learning of that task. It is safe to say that an adolescent will reach new heights as a result of success in meeting challenges and will reach new lows as a result of continuous failure. Success is important as an element of motivation particularly as it leads to the development of a positive self-concept and hence to further success and further motivation. There are two types of success, the first being vertical success. This is the concept that success at one level will lead to success at a higher level. This dictates that learning experiences be presented in a sequential, developmental hierarchy. In a therapeutic community, this sequence is very evident in the phase or level systems of program completion. It is important to set the stage for client success by providing readiness exercises, setting clear-cut, short-term and attainable goals, pointing to evidence of progress and not expecting too much too soon.

The second type of success is horizontal success. This is the concept that people who have success in one area will have success in other areas. It's a spread effect that success plays on the person's self-esteem and ability to meet new challenges. I have witnessed this repeatedly in the therapeutic community model. A client who is experiencing success in his job function will experience success in school, or success in school leads to success in groups which leads to success in family therapy and so on. Conversely, failure also has a spread effect.

4. *Interests.* Interests are acquired as a result of satisfying experiences and, once established, tend to perpetuate themselves as long as they are effective from the standpoint of the individual's goals and purposes. One of the therapeutic community's primary responsibilities is to foster new purposes, new motives and new interests. To do so, the therapeutic community must relate therapeutic community experience to the adolescent's motives and purposes. There must be relevance and purpose to the learning experience. Developmentally, the adolescent has the capacity to grow in ability to concentrate, to reason, to gain insight, to generalize and to use imagination. They find satisfaction in intellectual activity, becoming more creative, imaginative and precise in their work. It is therefore effective and necessary to build and foster the adolescent's field of life experiences and interests. For example, it is ineffective to teach adolescents the

concept of integrity without relating it to the role honesty plays in their present life experience in their family, their peer groups, in school.

5. *Visibility.* One method to motivate change is to make dominant or visible in the community the behavior or goal you wish to attain. This means lifting up success, however small, of clients, praising positive behavior, reinforcing positiveness through phase advancements, honors, awards, charts, and basically recognizing achievement in some concrete manner. For some reason, counselors sometimes feel this is too juvenile and that the type of clients we have in therapeutic communities would not respond. Yet, I have experienced the opposite. Recognition and rewards are very powerful in effecting change. Extrinsic rewards are just as important as intrinsic rewards. For example, how many of us work for merely the intrinsic satisfaction of helping others achieve self-actualization? We may fool others into thinking this is why we work so hard, but the reality of that very powerful extrinsic reward called a paycheck is a monthly dose of motivation.

6. *Involvement.* It is not enough for a person to simply learn about things, he needs to become involved in the learning process. A client is more motivated when actively involved in the learning process. This means simply presenting information and requiring clients to regurgitate that information back to us, will not lead to effective learning by the clients. Involving the client intellectually, emotionally, physically and socially in the learning is very effective. Group encounters is an example of this concept in action. Client A who verbally expresses (with emotional and social emphasis) a specific behavior in Client B that needs to be changed is actually learning and reinforcing that behavior change within himself. Client A will have greater retention of the lesson than Client B.

Thus, in summary, the element of motivation includes the factors of contagion, effectance, expectancy, interests, visibility and involvement.

Readiness

The second element of learning theory is Readiness. Readiness is a broad concept covering a wide variety of factors which may be grouped as follows:

1. *Physiological factors.* Behavior cannot take place unless there is sufficient maturation of the sense organs, the central nervous system, the muscles and other physiological equipment. Very basic to this factor is the physiological influence drug use has on learning. It was reported in an article from the New England Journal of Medicine in 1983 that marijuana intoxification impaired intellectual performance, including the ability to repeat in forward and backward order a succession of digits, to make a succession of repeated subtractions mentally, to form concepts, to speak coherently and to transfer material from immediate to longer term memory storage. Therefore a drug-free therapeutic community has an advantage over the public school system in the sense that it has enhanced the physiological readiness of an adolescent to learn by eliminating the physical impairment of drug use.

2. *Psychological factors.* The individual must have the proper motivation, a positive self-concept, and relative freedom from devastating emotional conflicts and other psychological impediments to be ready to learn. Within the definition of psychological factors of readiness, the therapeutic community has real strength. Because of the structured, consistent, and sequential nature of the therapeutic community program, adolescents are in an extremely psychologically safe environment. Within this psychological safety, adolescents are able to make significant gains academically, socially, emotionally and with their families. The clients we see in the therapeutic community are able to make these gains more quickly and I believe with greater retention than those with similar dysfunction in the regular school system, out-patient treatment or short-term residential treatment.

3. *Experiential factors.* With the exception of the learning that stems from inborn response tendencies, learning can take place only on the basis of previously learned skills and concepts. This reinforces the use of hierarchical systems in the therapeutic community. Learning experiences must be provided in a sequential, developmental hierarchy of skills.

Practice and Drill

Practice of a skill does not insure learning but it does allow for the time for learning to take place. Practice gives the learner an opportunity to use his knowledge in his climb to new heights. Systematic practice allows the learner to grasp gross meaning during the initial trials and to grasp more refined and subtle meanings on subsequent trials. In complex materials, practice enables the learner to test the correctness of his insights from the first trial, to clarify ambiguity, and to correct misconceptions. To be effective, practice and drill should be meaningful and purposeful, specific, varied, frequent and distributed, supervised, fairly uninterrupted, reinforced and capable of active involvement by the learner.

Relating this element of learning theory to the therapeutic community is quite simple. The therapeutic community involves treatment of the adolescent as a whole. Opportunity to practice knowledge occurs continuously because the therapeutic community is a microcosm of the adolescent's life. We must remember to provide practice not only of intellectual knowledge, but also social skills, emotional development, physical skills and family relations. The day to day activities of the therapeutic community should be structured for the sole purpose of providing practice of lifeskills and knowledge.

Retention

The goal of all learning is for that learning to be retained. The extent of retention depends on such factors as functionality of the material learned, and the interrelatedness of the components, the meaningfulness to the learner's background, intelligence and motivation, the adequacy of mastery and the nature of the learning process. To encourage retention several factors should be taken into consideration:

1. *Association cues.* The more associative cues a learner can form, the more likely he is to retain what he has learned. This can be enhanced by teaching the concept in a variety of settings so that it is associated with a variety of cues.

2. *Degree of Mastery.* All indications are that the crucial variable in retention is the degree of original learning. Good retention revolves around good learning. We must teach for mastery.

3. *Review.* Review is probably one of the best means of maintaining retention above a given level. Review brings about deeper understandings and new insights into relationships that are more functional as well as more permanent than the original learning.

4. *Set or Intent to Remember.* Retention is facilitated by having the client learn with full expectation of being tested on the material. Intent to remember is related to motivation which makes for maximum retention. If learning is to be retained, it cannot be learned passively. The learner, intent on remembering, is actively involved in the learning process.

To maximize retention, these elements should be considered when structuring learning experiences in the therapeutic community.

Reinforcement

Thorndike's "Law of Effect" states that, other things being equal, those responses followed by satisfying aftereffects tend to be learned. Inherent in the therapeutic community model are behavior modification techniques, designed to provide systematic reinforcement for good behavior, so that misbehavior is gradually eliminated through extinction and through displacement by positive alternatives.

What is also a potential danger in the therapeutic community is the overuse of aversion techniques. There is a need and benefit to have the therapeutic community environment stable, consistent and controlled to some extent. However, there is also a danger in the therapeutic community becoming rigid, autocratic and punitive. We need to be continually sensitive to the fact that petty rules, arbitrary regulations that serve no purpose, impossible standards, one-way communication, repressive discipline and other forms of rigid bureaucratic nonsense simply dehumanize and alienate those we are attempting to treat.

Transfer

Life is predicated on the assumption that what we learn on one occasion will facilitate our dealing with related situations in the future. Since, in the therapeutic community, we cannot possibly teach all that a client will need to know, we do need to teach for transfer of learning so the client will be able to adapt to new situations. Helping the client develop a cognitive structure of clear and stable foundations with an appropriate level of abstraction, generality and inclusiveness to which new learnings and experience can anchor is essential. A key to what learning will be transferred is the relevance of the material to the learner. Sometimes too, we have to assist clients in focusing what is relevant and meaningful. Especially in real-life situations, the main point is often obscured by nonessentials. And finally, the level at which the client has achieved self-actualization is crucial in determining whether transfer will occur. The client who has a positive attitude toward the experiences he encounters, a constructive self-concept, relative freedom from anxiety and maximum openness to new experiences will be the client who can approach new situations with eagerness and confidence in his ability to meet life's demands.

My purpose in describing these eight elements of learning theory was to highlight the factors in a therapeutic community that provide optimum potential for learning.

In as much as adolescent substance abuse is a disorder of the whole person, effective treatment must focus on a global change of the individual. Therefore, in treating adolescent substance abusers, attention must be given to the social, emotional, intellectual, psychological, physical and family relations components of learning. No one aspect can be ignored. The therapeutic community model of learning can provide a tremendous potential for unleashing the opportunities for young people to maximize self-actualization and productivity in later life.

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NEW MORNING FOR COLOMBIAN YOUTH

Dra. Josefina Gallardo de Parejo

Fundacion Nuevo Amanecer
Bogota, Colombia

The foundation Nuevo Amanecer (New Morning) is located in Bogota, Colombia. It is a non-profit organization with the aim of rehabilitating and re-educating adolescent drug users, ages 16 - 18 years old, who have had problems with the criminal justice system. The goal is to provide treatment and rehabilitation services so that these youths can play leadership roles in combating drug addiction among Colombian youth. The foundation consists of people of good will and proven moral character who volunteer professional and personal services to help realize our objectives.

The program was started on July 19, 1984 in order to provide services to families who didn't have sufficient resources to take their children to private programs where fees were too high. Nuevo Amanecer took as its role model the Hogares Crea International in Puerto Rico, directed by its founder, the sociologist Juan Jose Garcia, whose generous and spontaneous collaboration was greatly appreciated in helping our staff to learn administrative techniques, fund-raising, scientific and practical knowledge about how to help rehabilitate drug abusers.

Subsequently, in search of new information and experiences, we were invited by the State Department, through the United States Embassy in Colombia, to visit drug programs in Virginia, Washington D.C., Maryland and New York. We found some interesting programs, but couldn't put these to practice in Colombia, because of the differences in our youth, although we could identify with the struggle to free adolescents from such a threatening problem as drug abuse.

Later, we got in touch with Juan Corelli, founder of CEIS (Centro Italiano de Solidaridad) in Italy, a great and humane man, who cordially invited us to participate in the 8th World Conference of Therapeutic Communities in Rome. It was there I met Don Mario Picchi, who generously opened the doors of his TC, offering us the training we needed to apply TC principles and concepts to our program, Nuevo Amanecer, with magnificent results.

The first phase of treatment at Nuevo Amanecer is the "Acogida", whose basic object is to shelter the person in crisis, resolve immediate conflicts, and establish the motivation to change by providing an understanding of the necessity to change. Also, the purpose of this orientation phase is to begin the reconstruction of the family system, and give spiritual assistance. The Acogida can handle more than 120 juveniles, but currently holds 70, who voluntarily take part in this phase of the program, accompanied by their parents.

The Therapeutic Community, which is the second phase of the prog- ram, emphasizes work, responsibility, discipline and communication skills. Here the adolescents are exposed to the TC dynamics. This facility has the capacity for 80 residents. It is air-conditioned, well-equipped and ready to receive youths who come from the Acogida, who have been evaluated by a Committee of Professionals, including doctors, psychiatrists, social workers, and psychologists. In a month or two, we will have our first residents in this phase of treatment.

Nuevo Amanecer is sustained by the generosity of private institu- tions, CEIS, the Colombian Institute of Family Well-Being, the U.S. Embassy in Columbia, the constant and continuous support of volunteers, and with the parents and family members of residents who make up the Parent's Association.

The Director of the Institute of Family Well-Being has agreed to collaborate to establish a rural TC for youth, since there is enough land in Cajica to do this. Because we are getting such support, we expect that by the time we attend the 10th World Conference next year, that there will be numerous TCs in Colombia, established with the help of ex-addicts, families, young adult groups and various authorities, to which adolescent drug abusers will be diverted to, and from which young adult leaders will be trained.

Free-base cocaine is the most common drug among consumers. It may contain sulfuric acid, chloroform, kerosene and gasoline. It may cause anxiety, irrationality and paranoia. Gradually sexual desire is lost, causing frigidity and impotence. Emotional blockages, autism, and other irreversible nervous system disorders which destroy the personality can result.

Dependency upon the drug will make its users do anything in order to obtain it, including stealing (first of all in their own family), and both feminine and masculine prostitution. Since the drug makes studying or working impossible, it is understandable that many adolescent addicts are converted overnight into delinquency. Freebasing also produces a physical dependency. It is consumed from the lowest grades in school to the university. Although it is considered new on the market, freebase cocaine has been consumed in Colombia for 9 years, and this is why we are applying all our strength towards helping the youth of our country.

SPORTS, DRUG ABUSE AND TEENAGERS

Delvin Williams

Pros for Kids
San Mateo, California

Pros for Kids represents a new approach to the problem of curbing drug and alcohol abuse among teenagers. It is the inspiration of former San Francisco 49er running back Delvin Williams. Forced to an early retirement through drug problems, Williams has now dedicated his life to substance abuse prevention. His philosophy in forming Pros for Kids is to use celebrated professional and amateur athletes as role models for kids. Through a balanced program of athletic and academic endeavors, Pros for Kids translates many of the disciplines necessary in becoming a good athlete into the personal life style necessary to become a good citizen.

Since its inception three years ago, the organization has grown phenomenally and now handles three major balanced projects directed against drug and alcohol abuse; Pro Camps, TAP (Teen Alternative Program), and a Special Activities Program.

Pro Camps is a series of day camps set up in the summer months around the Bay Area. Here, celebrity athletes work with the kids on both athletic and academic programs strongly aimed toward curbing substance abuse.

The Teen Alternative Program, TAP, is a self-governing group of youngsters established to promote positive alternatives to drug and alcohol abuse. They publish a monthly newsletter and hold various educational activities.

Special Activities of Pros for Kids takes the message to all youngsters through such forums as school assemblies, conferences and community presentations. As with Pro Camps, celebrity athletes are used for these presentations.

BALANCE is the major theme used by athletes in working with the kids. A balanced approach to both academic and athletic endeavors is strongly stressed. Using their own personal experiences, pro athletes transfer to young people the need for dedication, clear goals, mental and physical preparation and a strong desire to succeed. The theme BALANCE has become the cornerstone of Pros for Kids. Its six major steps are:

1) How to be a winner. Preparation.

2) Overcome barriers to excellence. Basic techniques.

3) Realize full abilities. Conditioning.

4) Go for the gold. Plan of attack.

5) Be a winner. Execution.

6) Maintain perseverance. Evaluation.

The person really Isn't bad,
The person is really good. inside